Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Editorial

COVID-19 and mental health: Preserving humanity, maintaining sanity, and promoting health

In the midst of chaos, there is also opportunity- Sun Tzu

As the COVID-19 pandemic rages on, the enormous magnitude of the devastation that it has wreaked across the world is becoming apparent. There are over 5 million confirmed cases of SARS-CoV-2 infection and over 325,000 deaths attributed to COVID-19 distributed across 213 countries/territories and the world economy has plummeted into a deep recession. As nations around the world begin to slowly reopen their economies and gradually emerge from lockdowns/shelter in place, there is a stark realization that SARS-CoV-2 continues to attack us and that we are, at best, nearing the end of the first quarter of this war against the virus. Thus far, most of our efforts at containing the direct health effects of the virus have been directed at flattening the curve. We are slowly beginning to come to terms with the scale of the "collateral damage" to all aspects of our life caused both by the pandemic and our response to it (school closures, workplace closures, stay-at-home restrictions, cancellation of public events, restrictions on socialization and public gatherings, restrictions on international and internal travel, etc.). Experts are now predicting a "tsunami of psychiatric illness", with the Secretary-General of the United Nations (Guterres, 2020), the Director-General of the World Health Organization (Ghebreyesus, 2020), and the President-Elect of the World Psychiatry Association (DeSousa et al., 2020) calling attention to this impending mental health crisis. Although definitive information is lacking, rates of suicide, substance use disorders, domestic abuse, anxiety and depressive disorders are already reported to be increasing around the world

In my last editorial (Tandon, 2020), I had committed that the Asian Journal of Psychiatry would strive to play its role in the dissemination of good information relevant to COVID-19 and mental health. At that time (early March, 2020), we had received 10 articles and published four on the topic. When in the editorial, I invited additional articles with the promise of an expeditious review, little did I realize that we would receive over 550 submissions related to COVID-19 over a 6-week period. We publish 52 articles on the subject in this issue (Volume 51). I want to thank all the authors for their work on the topic, including those whose manuscripts were not accepted for publication and the many reviewers who enabled a fair and rapid review process. In the interests of full transparency, I wish to apprise you about the decision-making process and some key considerations/challenges in this endeavor.

1. The editor's challenge

Scientific Journals are a medium of communication between authors and readers. The editorial process serves an intermediary function with the objectives of facilitating transmission of valid, useful knowledge while screening out poor quality or irrelevant material (Tandon, 2014). In an international healthcare crisis such as the COVID-19 pandemic, real-time dissemination of accurate information becomes critical in order to enable healthcare and policy decision-making in a situation of urgency with substantial uncertainty. This compels the Editor to adjust the balance between comprehensive and speedy manuscript processing in order to make valid information available expeditiously (Rankupalli and Tandon, 2010).

2. Modifications in review process

In order to facilitate an expeditious, yet rigorous and fair process, I initially sent copies of each manuscript to two reviewers who were asked to peruse the manuscript and provide cursory feedback within two days- grade articles from i-iv: (i) definitely publish/(ii) probably publishable/(iii) marginal/(iv) do not publish based on their assessment of relevance, originality, and quality. I read each of these manuscripts and limited my initial editorial decision to (a) accept as is; (b) needs minor revisions without a more detailed review; (c) obtain formal extensive reviews; (d) reject with invitation to resubmit in a more concise format; or (e) desk reject. I based this determination on the input from the two reviewers who perused the manuscript along with my own assessment of the article with the additional consideration of breadth of coverage. If the initial decision was (b) minor revisions without review, I immediately sent a decision letter to the authors with specifics about recommended revisions. If the initial decision was (c) need for formal extensive review, reviewers were promptly identified and asked to submit their reviews within a week. Within two days of receipt of revised versions, an editorial decision was made (accept, revise, reject). Next steps in article processing were promptly initiated. This process worked well for the first 400 articles with initial editorial decisions for all being made within a week of submission. The median time for the 52 accepted articles in this volume to be on line from their date of submission was 10 days. I was unable to maintain this pace for about the past two weeks, but we have now resumed our ability to make initial editorial decisions within a week.

An additional editorial challenge was the receipt of a large number of manuscripts of variable quality and relevance. Authors understandably responded to the opportunity and sense of urgency of the situation by seeking to share preliminary experiences, hastily gathered data, or partially developed ideas with the field at large. In addition to the review process outlined above, authors of potentially useful but preliminary or opinion-laden submissions were asked to condense their manuscripts into a more concise format such as Correspondence – along with content, the format helps readers recognize the less definitive nature of the contribution. While publishing a large number of Letters to the Editor has downstream effects such as lowering our Impact Factor, we believe that this was the right course of action. Finally, there

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appears to be an increased risk of duplicate publication- one of the accepted manuscripts had to be retracted from this volume for this reason. While this form of self-plagiarism is uncommon (Mohapatra and Samal, 2014), authors are reminded that ethical standards of scientific publishing do not become any less rigorous during global healthcare emergencies and this Journal remains vigilant in guarding against any form of scientific misconduct.

One downside of our revised editorial process was the increase in the proportion of desk rejections of articles (after preliminary reviewer input) with the inability to provide their authors with detailed reviewer comments- though unavoidable in the context of rapid processing of such a large volume of manuscripts, I do want to acknowledge this shortcoming.

3. Journal innovations and looking ahead

We considered a special issue exclusively on COVID-19 and mental health but decided against it for two reasons. COVID-19 is still raging and its mental health consequences will unfold over time, and this necessitates not one-time but continuing coverage of the topic. Of greater import, other mental health problems have not gone away and our relative inattention to them in the context of our almost single-minded attention to the COVID-19 pandemic may worsen morbidity and mortality associated with them.

In this volume, the Journal introduces a new article format called Perspectives. Experts are solicited to author a commentary on a topic of high import and relevance. In volume 51, three eminent physician-scientists (Jenson, 2020; Keshavan, 2020; and Patel, 2020) present their outlook on three different topics relevant to COVID-19 and mental health. With distinct points of view, they share their thinking about the mental health impact of the pandemic, our response, the challenges, and opportunities.

In the next volume, there will be several reviews and perspective pieces on a range of topics relevant to COVID-19 including:

(i) opportunities and challenges of telepsychiatry and mental health apps;

(ii) learnings from previous viral outbreaks- what we can and cannot learn from history;

(iii) experience of residency training during this time and risks of moral injury and resilience;

(iv) impact of the pandemic on people in Asia, differences in national response and their effects across the 50+ nations across Asia (Tandon and Nathani, 2018);

(v) misguided dichotomization of health versus economy;

(vi) neurobiological and mental health effects of SARS-CoV-2 and the body's response to the infection;

(vii) bioethical considerations in addressing mental health challenges in the context of COVID-19;

(viii) mental health problems and appropriate interventions for the general population and vulnerable groups- healthcare workers, persons with significant medical comorbidities, the elderly, and those with pre-existing serious mental illness.

4. Learning from Data (with its limitations!)

Although pandemics are not new, COVID-19 is unique in terms of the breadth, magnitude, and rapidity of its impact on mankind. People across 200+ countries across the world have simultaneously been impacted over a short period of time with over half the world in a lock-down and all national economies plummeting into a recession. As of today, there have been over 5 million confirmed cases and 325,000 deaths associated with COVID-19 across the world. Although the pandemic originated in Asia (Wuhan, the capital city of the Hubei province in China), it appears to have disproportionately impacted countries in Western Europe and North America. With 60 percent of the world's population, Asia accounts for 17 % of the confirmed cases and 8% of the worldwide mortality associated with COVID-19. There is significant variation in the confirmed occurrence of COVID-19 and associated mortality across countries in Asia (Table 1).

Table 1
Confirmed Cases of SARS-CoV-2 Infection and Confirmed Deaths due to COVID across Asia- May 20, 2020.

COUNTRY	Confirmed Cases May 20, 2020	Reported Deaths May 20, 2020	Deaths per 1 million population
	COUNTRIES FULLY	IN ASIA	
Afghanistan	8145	187	5
Bahrain	7886	12	7
Bangladesh	26,738	386	2.3
Bhutan	21	0	–
Brunei Darussalam	141	1	2
Cambodia	122	0	–
China	82,965	4634	3.2
India	112,028	3434	2.5
Indonesia	19,189	1242	4.8
Iran	126,949	7183	86
Iraq	3724	134	3.3
Israel	16,667	279	32
Japan	16,367	768	6
Jordan	672	9	0.9
Kazakhstan	6969	35	2
Kuwait	17,568	124	29
Kyrgystan	1270	14	2.2
Laos	19	0	–
Lebanon	961	26	4
Malaysia	7009	114	3.7
Maldives	1186	4	7.4
Mongolia	140	0	–
Myanmar	193	6	0.1
Nepal	427	2	0.1
North Korea	0*	0*	-*
Oman	6043	30	5.9
Pakistan	45,898	985	4.5
Palestine	398	2	0.4
Philippines	13,221	842	7.8
Qatar	37,097	16	6
Saudi Arabia	62,545	339	10
Singapore	29,364	22	4
South Korea	11,110	263	5
Sri Lanka	1028	9	0.4
Syria	58	3	0.2
Taiwan	440	7	0.3
Tajikistan	2140	41	4.3
Thailand	3034	56	0.8
Timor-Leste	24	0	–
Turkmenistan	0*	0*	–*
United Arab Emirates	26,004	233	24
Uzbekistan	2939	13	0.4
Vietnam	324	0	–
Yemen	184	30	1
	COUNTRIES PARTLY IN	ASIA & EUROPE/ AFRICA	
Armenia	5271	67	23
Azerbaijan	3631	43	4
Cyprus	922	17	14
Egypt	14,229	680	7
Georgia	713	12	3
Russia	308,705	2972	20
Turkey	152,587	4222	50

Comparison of these statistics across countries is problematic because of the many differences in methods of ascribing deaths to COVID-19, significant differences in rates of testing for SARS-CoV-2 infection, varying quality of data collection and aggregation, and questions about the accuracy of official reporting across countries. Additionally, relative numbers continue to change across the world as the viral pandemic is at different stages of evolution. But these are the only numbers we have

and with the caveat of the need for extremely cautious interpretation, some trends are worth noting:

a) Iran is the only nation fully in Asia that is among the top 10 countries with the highest number of confirmed cases (#10). Russia and Turkey (two countries partly in Asia) are #2 and #9 when countries are ranked in order of the number of confirmed cases. The other countries are in Western Europe and the Americas.

b) In terms of COVID-19 associated per-capita mortality, countries in Western Europe (Spain, Italy, United Kingdom, France, and Germany in that order) and North America (United States of America and Canada) have the highest rates that exceed those in any country in Asia- Iran has the highest mortality rate in Asia followed by three other countries in West Asia (Israel, Kuwait, and the United Arab Emirates).

c) The manner in which the SARS-CoV-2 infection spread into and across various countries and their approach to managing the COVID-19 pandemic has differed substantially. Within the significant constraints of the data, available information suggests:

(i) An early aggressive containment strategy (in East Asia as in South Korea, Singapore, and Taiwan; perhaps China after initial delays in Wuhan) or an early aggressive mitigation strategy (as in South Asia) may have reduced infection rates and mortality related to COVID-19;

(ii) The younger average age of populations in most Asian countries compared to Western Europe likely was an important factor in observed lower mortality rates in Asia. The average age in Japan, however, is comparably high and yet mortality rates there were low;

(iii) Colder temperatures (higher latitude) may have been a factor in the different outcomes in Asia versus Western Europe and North America, although Beijing in China has the same latitude as New York in the USA;

(iv) South-East Asia (via ASEAN) and South Asia (via SAARC) attempted regional cross-national approaches to supplement national containment/mitigation strategies and this may have contributed to better outcomes in those groups of countries thus far;

(v) As in all countries, the elderly and those with comorbid chronic medical illnesses had the worst outcomes and the highest mortality;

(vi) In Kuwait and the United Arab Emirates, a disproportionate number of confirmed cases and COVID-19 associated deaths have occurred among migrant workers. Migrant workers in other Asian countries have also experienced relatively worse outcomes than indigenous or non-migrant populations, suggesting that they also constitute a more vulnerable group.

While it is imperative that we do not over-interpret or read too much into the data, we can begin learning some lessons relevant to addressing mental health needs of different affected populations.

5. The opportunity amidst tragedy and uncertainty

The pandemic has exposed weaknesses in our public health preparedness and structure of our healthcare systems. The paradoxically worse outcomes in better developed countries with seemingly stronger healthcare systems (Western Europe and North America) warrants careful examination. At a minimum, we have learned that we are all vulnerable and must share the global responsibility of addressing the worldwide shared vulnerability to infectious diseases with pandemic potential. It is notable that we have thus far failed to learn from the previous viral outbreaks of this century (H1N1 and SARS influenza; Ebola, MERS, etc.) - common vulnerability, our weak existing global outbreak surveillance system, and the virtues of an integrated global response. In contrast to the better coordinated international response to the Ebola outbreak, for example, there has been a glaring absence of effective global leadership during this pandemic and this has been extremely costly. Instead of collective problem-solving, nations are engaging in punitive blame games. While mistakes have certainly been made by several parties, a global pandemic calls for a global solution and global collaboration. We are in this together. Additionally, there is a lot of misinformation which increases distrust and fear, adds to the uncertainty, and further clouds decision-making. As clinicians and scientists, we have an important responsibility to combat conspiracy theories and rumors while promoting dissemination of accurate information of what we know, what we don't know, and what this information means. As societies begin to reopen from their lockdowns, we must make decisions that minimize lives lost (from all causes) and also recognize that there is no dichotomy between protecting lives and protecting our economy. The pandemic has also exposed glaring health disparities and this should provide an impetus for reducing such inequities.

As we get ready to be inundated by the short-term and long-term mental health impact of the continuing COVID-19 pandemic, let us be guided by the best data and learn to apply it with grace, humility and diligence. We owe our patients and our profession no less. The Asian Journal will play its small part.

> We cannot solve our problems with the same thinking we used when we created them- Albert Einstein

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